MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address STAT 2000 PO Box 15640 Ft. Worth TX 76119-0640	MDR Tracking No.: M4-03-7223-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 27 Hartford Casualty Ins. Co. PO Box 802517 Dallas TX 75380	Date of Injury: Employer's Name: United Services Auto. Assoc. Insurance Carrier's No.: 690C 19739

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
5/28/02	**9/28/02**	**E1399**	**$425.00**	**$425.00**

PART III: REQUESTOR'S POSITION SUMMARY

6/17/03: "The disputed issue is that the Carrier has denied the claims stating not documented…The treating doctor has stated that the services are necessary and related to the work injury per his letter…Section 408.021…entitled…Rule 133.3 (a-c)…responsibilities of treating doctor…"

PART IV: RESPONDENT'S POSITION SUMMARY

7/9/02: "…The service in question is the monthly supplies for a neuromuscular stimulator. The Carrier requested a letter of medical necessity for the continued use of the stimulator…The patient has not received a prescribed medication since 1998, and the last medical visit to the doctor…in December 2000…in accordance with section 408.021…MFG IX, B, 1,2,3, the statement of necessity shall include diagnosis, prognosis, and expected duration…supplies will be required…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

* CPT Code E1399 (D0555, muscle stimulator supplies) for five (5) DOS's- 5/28/02 through 9/28/02, were denied as "N – Our records indicate that the patient is not currently obtaining medical care. Please submit documentation demonstrating medical justification for continued use."

* Per the 2/5/02 office visit, documentation submitted supports reimbursement according to section 408.021, Rule 133.304(i) and MFG, DME, IX, B. Recommended amount due: $425.00.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
5/28/2002	E1399	$85.00	$85.00				
6/28/2002	E1399	$85.00	$85.00				
7/28/2002	E1399	$85.00	$85.00				
8/28/2002	E1399	$85.00	$85.00				
9/28/2002	E1399	$85.00	$85.00				
						Total Left Column:	$425.00
						Total Amount Due:	$425.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $425.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Carol Lawrence	03/18/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____